



General

Guideline Title

Health maintenance in the long term care setting.

Bibliographic Source(s)

American Medical Directors Association (AMDA). Health maintenance in the long term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2012. 50 p. [74 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Health maintenance in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2007. 27 p.

Recommendations

Major Recommendations

Note from the American Medical Directors Association (AMDA) and the National Guideline Clearinghouse (NGC): The original full-text guideline provides an algorithm on "Health Maintenance in the Long Term Care Setting" to be used in conjunction with the written text. Refer to the "Guideline Availability" field for information on obtaining the algorithm, as well as the full text of the guideline, which provides additional details.

Levels of evidence (High, Moderate, Low) and grades of recommendation (Strong, Weak, Insufficient) are defined at the end of the "Major Recommendations" field.

General

1. Health maintenance decisions in long term care (LTC) settings should be guided by functional status and probable life expectancy, as well as by the patient's preferences, goals of care, values, and wishes, rather than by age alone. (Quality of Evidence: Low; Strength of Recommendation: Strong)
2. Health maintenance recommendations should be individualized. (In frail older adults, the burdens of some screening tests may outweigh the benefits.) Standard guidelines for preventive care may be inappropriate when applied to frail populations such as the institutionalized elderly. (Quality of Evidence: Low; Strength of Recommendation: Strong)
3. Every LTC facility should implement a system for documenting each patient's prognosis, values, goals, and wishes, as well as any advance directives, so that this information is available in the medical record to facilitate clinical decision making. (Quality of Evidence: Low; Strength of Recommendation: Strong)
4. Every LTC facility should develop a health maintenance protocol for each patient, including individualized goals that can be translated into

standing orders for the patient's care. (Quality of Evidence: Low; Strength of Recommendation: Weak)

5. When no preventive intervention approach is clearly medically preferred, the practitioner should explain to the patient and family the risks, benefits, and any alternatives to the intervention and help them to arrive at a reasonable decision to proceed with the intervention or not. (Quality of Evidence: Low; Strength of Recommendation: Strong)

Recognition

6. Following a comprehensive admission assessment, a comprehensive problem list should be prepared for each patient and maintained in the medical record. (Quality of Evidence: Low; Strength of Recommendation: Strong)
7. All patients of LTC facilities should be encouraged to complete advance directives and clarify their treatment preferences. (Quality of Evidence: Low; Strength of Recommendation: Strong)
8. The patient's plan of care should be reviewed and revised as necessary. (Quality of Evidence: Low; Strength of Recommendation: Strong)

Assessment

9. Evaluate the benefits, risks, and the time to benefit from an intervention in the context of the patient's life expectancy, preferences, and goals of care. (Quality of Evidence: Low; Strength of Recommendation: Strong)
10. Screening for dyslipidemia may be appropriate for older adults who have not previously been screened. Repeat screening at annual intervals, however, is less important in older people because lipid levels are less likely to increase after age 65. (Quality of Evidence: Moderate; Strength of Recommendation: Weak)
11. Osteoporosis screening may be appropriate for certain individuals in LTC, such as a female patient who is admitted to the facility after a recent hospitalization for hip fracture, has not previously been screened for osteoporosis, and is not already receiving pharmacologic interventions to improve bone density. Although no evidence-based recommendations concerning screening frequency are available, it is reasonable in the LTC setting to screen these patients at least once. (Quality of Evidence: Low; Strength of Recommendation: Weak)
12. Because vitamin D insufficiency is common in older adults, it may be advisable to measure 25-hydroxyvitamin D levels in selected patients. (However, no established guidelines exist to help in the identification of patients who should be screened for vitamin D deficiency.) (Quality of Evidence: High; Strength of Recommendation: Strong)

Treatment/Intervention

13. Suggested criteria for performing various health maintenance interventions

General

- Level of function/activity of daily living (ADL) (Quality of Evidence: Low; Strength of Recommendation: Strong)
- Medications (Quality of Evidence: Low; Strength of Recommendation: Strong)
- Osteopenia (Quality of Evidence: Low; Strength of Recommendation: Weak)
- Pressure ulcers (Quality of Evidence: High; Strength of Recommendation: Strong)
- Renal function (Quality of Evidence: Low; Strength of Recommendation: Insufficient)
- End of life (Quality of Evidence: Low; Strength of Recommendation: Strong)

Disease Prevention

- Influenza vaccination (Quality of Evidence: High; Strength of Recommendation: Strong)
- Osteoporosis (Quality of Evidence: Low; Strength of Recommendation: Weak)
- Pneumococcal pneumonia (Quality of Evidence: Moderate; Strength of Recommendation: Strong)
- Shingles/post-herpetic neuralgia (PHN) (Quality of Evidence: Moderate; Strength of Recommendation: Strong)
- Tetanus (Quality of Evidence: Moderate; Strength of Recommendation: Strong)

Lifestyle

- Alcohol, drug use (Quality of Evidence: Low; Strength of Recommendation: Strong)
- Environmental safety (Quality of Evidence: Low; Strength of Recommendation: Strong)
- Frailty (Quality of Evidence: Low; Strength of Recommendation: Insufficient)
- Human immunodeficiency virus (HIV) (Quality of Evidence: Moderate; Strength of Recommendation: Strong)
- Risky sexual activity (Quality of Evidence: Low; Strength of Recommendation: Strong)
- Tobacco use (Quality of Evidence: High; Strength of Recommendation: Strong)

Screening

- Delirium (Quality of Evidence: High; Strength of Recommendation: Strong)
- Dementia (Quality of Evidence: Moderate; Strength of Recommendation: Strong)

- Depression (Quality of Evidence: High; Strength of Recommendation: Strong)
- Diabetes (Quality of Evidence: Low; Strength of Recommendation: Weak)
- Fall risk (Quality of Evidence: High; Strength of Recommendation: Strong)
- Hearing impairment (Quality of Evidence: Low; Strength of Recommendation: Strong)
- Hyperlipidemia/lipid risk (Quality of Evidence: Moderate; Strength of Recommendation: Weak)
- Hypertension (Quality of Evidence: Moderate; Strength of Recommendation: Insufficient)
- Nutrition risk/weight loss or gain (Quality of Evidence: High; Strength of Recommendation: Strong)
- Oral health (Quality of Evidence: High; Strength of Recommendation: Strong)
- Pain (Quality of Evidence: High; Strength of Recommendation: Strong)
- Tuberculosis (Quality of Evidence: High; Strength of Recommendation: Strong)
- Vision impairment (Quality of Evidence: Low; Strength of Recommendation: Insufficient)

Cancer Screening

- Breast cancer (Quality of Evidence: Moderate; Strength of Recommendation: Weak)
- Cervical cancer (Quality of Evidence: Moderate; Strength of Recommendation: Strong)
- Colon cancer (Quality of Evidence: Moderate; Strength of Recommendation: Strong)
- Prostate cancer (Quality of Evidence: High; Strength of Recommendation: Strong)
- Skin cancer (Quality of Evidence: Low; Strength of Recommendation: Insufficient)

Psychosocial/Spiritual

- Abuse or neglect (Quality of Evidence: High; Strength of Recommendation: Strong)
 - Cultural factors (Quality of Evidence: Low; Strength of Recommendation: Strong)
 - Spiritual needs (Quality of Evidence: Low; Strength of Recommendation: Strong)
14. Influenza vaccination is a high-impact, cost-effective, primarily preventive service for people aged 65 years or more and should be a high-priority intervention in this population. Influenza vaccination is also cost-effective for persons aged 50 to 64. (Quality of Evidence: High; Strength of Recommendation: Strong)
 15. Specific evidence and recommendations for lowering low density lipoprotein (LDL) cholesterol in the LTC population are limited and treatment considerations should be individualized. (Quality of Evidence: Low; Strength of Recommendation: Weak)
 16. The patient, family, and primary care practitioner should reach agreement on the health maintenance plan. (Quality of Evidence: Low; Strength of Recommendation: Strong)
 17. The patient's individualized health maintenance plan should be integrated into the overall care plan to ensure that health maintenance interventions are carried out in accordance with the plan and continue to be appropriate. (Quality of Evidence: Low; Strength of Recommendation: Strong)

Monitoring

18. The patient's health maintenance plan should be reviewed and revised at least annually. (Quality of Evidence: Low; Strength of Recommendation: Strong)
19. The facility's implementation of health maintenance interventions should be reviewed through the quality improvement process. (Quality of Evidence: Low; Strength of Recommendation: Strong)

Definitions:

Quality of Evidence

The quality of evidence indicates the extent to which one can be confident that an estimate of effect is correct.

High: At least 1 randomized controlled trial OR 3 pre/post interventions or other prospective interventions or 3 well-structured, relevant observational studies

Moderate: Studies that use well-tested methods to make comparisons in a fair way, but where the results leave room for uncertainty (e.g., because of the size of the study, losses to follow-up, or the method used for selecting groups for comparison)

Low: Studies in which the results are doubtful because the study design does not guarantee that fair comparisons can be made

Strength of Recommendation

The strength of a recommendation indicates the extent to which one can be confident that adherence to the recommendation will do more good

than harm.

- Strong: Benefits clearly outweigh risks.
- Weak: Benefits are balanced with risks.
- Insufficient: Evidence is inadequate to make a recommendation.

Clinical Algorithm(s)

A clinical algorithm for health maintenance in the long term care setting is provided in the original guideline document.

Scope

Disease/Condition(s)

Conditions or diseases of the elderly

Guideline Category

Evaluation

Prevention

Risk Assessment

Screening

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Nursing

Preventive Medicine

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Pharmacists

Physician Assistants

Physicians

Social Workers

Guideline Objective(s)

- To improve the quality of care delivered to patients in long term (LTC) care settings
- To provide evidence-based guidelines focused primarily on primary prevention for the frail elderly LTC population

Target Population

Residents of long term care (LTC) facilities (primarily the frail elderly)

Interventions and Practices Considered

Evaluation/Risk Assessment

1. Identifying the patient's diagnoses and conditions at the time of admission or reassessment
2. Reviewing the patient's goals of care and advanced directives
3. Reviewing the patient's existing plan of care and revising as necessary
4. Clarifying the pertinence of potential interventions for the individual patient
 - Cancer screening
 - Screening for dyslipidemia
 - Osteoporosis screening (in women and men)
 - Vitamin D supplementation

Management/Prevention

1. Developing a preliminary, individualized health maintenance plan for performing various health maintenance interventions
 - General interventions
 - Disease prevention
 - Lifestyle
 - Screening
 - Cancer screening
 - Psychosocial/spiritual
2. Reaching agreement on the health maintenance plan with the patient, family, and primary care practitioner
3. Implementing the patient's health maintenance plan
4. Reassessing the patient's health maintenance status
5. Monitoring the facility performance in implementing health maintenance interventions

Major Outcomes Considered

Benefits and risks of health maintenance interventions

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The clinical practice committee vice-chair performs a systematic literature search for the topic of the guideline, using the electronic databases MEDLINE, PubMed, etc. Each year the Steering Committee reviews all American Medical Directors Association (AMDA) clinical practice guidelines that are 3 years old and commissions a thorough literature review to determine whether the content of each guideline remains current. If

new literature does not change the content or scope of the original guideline, it is deemed to be current.

For this guideline revision, databases were searched between June 2009 and January 2011 for updated literature related to health maintenance in the long term care setting. Inclusion criteria included the elderly, long term care, and health maintenance topics. The following search terms were used: elderly, long term care, nursing home, health maintenance, bone mineral density measurement, mammogram, pap smear, colonoscopy, colon cancer screening in elderly, PSA, hyperlipidemia, osteoporosis, pneumococcal vaccine, herpes zoster vaccine, tetanus booster, smoking cessation counseling.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality of Evidence

The quality of evidence indicates the extent to which one can be confident that an estimate of effect is correct.

High: At least 1 randomized controlled trial *OR* 3 pre/post interventions or other prospective interventions or 3 well-structured, relevant observational studies

Moderate: Studies that use well-tested methods to make comparisons in a fair way, but where the results leave room for uncertainty (e.g., because of the size of the study, losses to follow-up, or the method used for selecting groups for comparison)

Low: Studies in which the results are doubtful because the study design does not guarantee that fair comparisons can be made

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Grading System for American Medical Directors Association (AMDA) Clinical Practice Guidelines

Judgments about the quality of evidence (see the "Rating Scheme for the Strength of the Evidence" field) require assessing the validity of results for important outcomes in individual studies. Explicit criteria should be used in making these judgments. In the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) Working Group approach, a systematic review of available evidence guides these judgments.

Sequential judgments are made concerning the following factors:

- The quality of evidence across studies for each important outcome
- Which outcomes are critical to a decision
- The overall quality of evidence across these critical outcomes
- The balance between benefits and harms
- The strength of recommendations

Reviewers consider four key elements: study design, study quality, consistency, and directness.

Definitions

Study design refers to the basic study design (broadly, observational studies and randomized trials).

Study quality refers to the detailed study methods and execution. Appropriate criteria are used to assess study quality for each important outcome. For randomized trials, for example, these criteria might include the adequacy of allocation concealment, blinding, and follow up. Reasons for downgrading a quality rating must be explicit (e.g., failure to blind patients and physicians reduced the quality of evidence for an intervention's impact on pain severity, a serious limitation).

Consistency refers to the similarity of effect estimates across studies. If there is important unexplained inconsistency in study results, confidence in the effect estimate for that outcome is reduced.

Directness refers to the extent to which the people, interventions, and outcome measures in the studies are similar to those of interest. For example, the directness of the evidence may be uncertain if the people of interest are older, sicker, or have more comorbidity than those in the studies. To determine whether important uncertainty exists, one can ask whether there is a compelling reason to expect important differences in the effect size. Because many interventions have more or less the same relative effects across most patient groups, reviewers should not use overly stringent criteria in deciding whether evidence is direct.

Criteria

Criteria for *decreasing* the grade:

- Serious (-1) or very serious (-2) limitation to study quality
- Important inconsistency (-1)
- Some (-1) or major (-2) uncertainty about directness
- Imprecise or sparse data (-1)
- High probability of reporting bias (-1)

Criteria for *increasing* the grade:

- Strong evidence of association: Significant relative risk greater than 2 (less than 0.5), based on consistent evidence from two or more observational studies, with no plausible confounders (+1)
- Very strong evidence of association: Significant relative risk greater than 5 (less than 0.2), based on direct evidence with no major threats to validity (+2)
- Evidence of a dose-response gradient (+1)
- All plausible confounders would have reduced the effect (+1)

These criteria are cumulative – e.g., if randomized controlled trials (RCTs) have serious limitations and there is uncertainty about the directness of the evidence, the grade of evidence would drop from high to low.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Original guidelines are developed by interdisciplinary workgroups, using a process that combines evidence- and consensus-based approaches. Workgroups include practitioners and others involved in patient care in long term care facilities (LTCs). Beginning with pertinent literature searches for articles and information related to the guideline subject and a draft outline/framework, each group works to develop a concise, usable guideline that is tailored to the LTC setting. Because scientific research in the LTC population is limited, many recommendations are based on findings from research involving community-living older adults. Some recommendations are based on the expert consensus opinion of practitioners and experts in the field of geriatric medicine.

The American Medical Directors Association (AMDA) Clinical Practice Guideline Steering Committee directs the guideline development and revision process. Each year the Steering Committee reviews all AMDA clinical practice guidelines that are 3 years old and commissions a thorough literature review to determine whether the content of each guideline remains current. The AMDA Clinical Practice Committee Chair selects the existing guidelines to be revised and new guidelines to be created based on 1) the Steering Committee's recommendations, 2) data collected, and 3) an assessment of the difficulty of development and relevance to the AMDA membership. AMDA's Board of Directors has final approval over this process.

Grading System for AMDA Clinical Practice Guidelines

The system AMDA has adopted for grading clinical practice guidelines (see the "Rating Scheme for the Strength of the Recommendations" field) is based on the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Working Group Approach.

Sequential judgments are made concerning the following factors:

- The quality of evidence across studies for each important outcome
- Which outcomes are critical to a decision
- The overall quality of evidence across these critical outcomes
- The balance between benefits and harms
- The strength of recommendations

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

The strength of a recommendation indicates the extent to which one can be confident that adherence to the recommendation will do more good than harm.

- Strong: Benefits clearly outweigh risks.
- Weak: Benefits are balanced with risks.
- Insufficient: Evidence is inadequate to make a recommendation.

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

All American Medical Director Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long term care setting.

AMDA's guidelines are supported by the following associations/organizations, who are members of its Clinical Practice Guideline Steering Committee. These associations/organizations all have representatives who participate in the external review phase and officially sign off on the guideline before publication: American Association of Homes and Services for the Aging (now LeadingAge); American College of Health Care Administrators; American Geriatrics Society; American Health Care Association; American Society of Consultant Pharmacists; Gerontological Advanced Practice Nurses Association; Direct Care Alliance; National Association of Directors of Nursing Administration in Long Term Care; National Association of Health Care Assistants.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based approaches. Because scientific research in the long term care population is limited, many recommendations are based on findings from research involving community-living older adults. Some recommendations are based on the expert consensus opinion of practitioners and experts in the field of geriatric medicine.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Early detection and prevention of illness may reduce morbidity and mortality in older adults, especially among those who are at the greatest risk of developing and dying from disease.
- Improved health and well-being of patients
- More appropriate resource utilization
- A reduction in the number of patients who receive inappropriate interventions or care
- An increase in the number of patients who receive appropriate interventions and care
- Facilitation of patient-centered care goals (i.e., goals that are appropriate to patients' needs and wishes)
- Improved awareness among health care providers and facility staff of appropriate preventive health interventions for patients in the long term care (LTC) setting
- Better-informed patients and patients' families or advocates, with more appropriate expectations about patients' care goals
- Improved quality outcomes and reporting to government and other agencies

See Table 1 in the original guideline document for benefits of selected health maintenance interventions.

Potential Harms

- In frail older adults, the burdens of some screening tests may outweigh the benefits. See Table 1 in the original guideline document for risks of selected health maintenance interventions.
- Information concerning the risk of atypical femur fractures has been added to the labeling of bisphosphonate medications approved to prevent or treat osteoporosis (e.g., alendronate, ibandronate, risedronate). The U.S. Food and Drug Administration recommends that practitioners "discontinue potent antiresorptive medications (including bisphosphonates) in patients who have evidence of a femoral shaft fracture."

Qualifying Statements

Qualifying Statements

- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association (AMDA), its heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of the AMDA's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and caregivers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinicians' ability to practice.
- AMDA guidelines emphasize key care processes and are created to be used in conjunction with facility-specific policies and procedures that guide staff and practitioner practices and performance. They are meant to be used in a manner appropriate to the population and practice of a particular facility. Guideline implementation may be affected by resources available in the facility, including staffing, and will require the involvement of all those in the facility who have a role in patient care.
- Long term care facilities care for a variety of individuals, including younger patients with chronic diseases and disabilities, short-stay patients needing postacute care, and very old and frail individuals suffering from multiple comorbidities. When a workup or treatment is suggested, it is crucial to consider whether such a step is appropriate for a specific individual. A workup may not be indicated if the patient has a terminal

or end-stage condition, if it would not change the management course, if the burden of the workup is greater than the potential benefit, or if the patient or his or her legally authorized representative would refuse treatment. It is important to carefully document in the patient's medical record the reasons for decisions not to treat or perform a workup or for choosing one treatment approach over another.

Implementation of the Guideline

Description of Implementation Strategy

The implementation of all clinical practice guidelines (CPGs) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

I. Recognition

- Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG.

II. Assessment

- Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes.

III. Implementation

- Identify and document how each step of the CPG will be carried out and develop an implementation timetable.
- Identify individual responsible for each step of the CPG.
- Identify support systems that impact the direct care.
- Educate and train appropriate individuals in specific CPG implementation and then implement the CPG.

IV. Monitoring

- Evaluate performance based on relevant indicators and identify areas for improvement.
- Evaluate the predefined performance measures and obtain and provide feedback.

Table 8 in the original guideline document suggests indicators that a facility might use to measure its success in implementing appropriate health maintenance approaches.

Implementation Tools

Audit Criteria/Indicators

Chart Documentation/Checklists/Forms

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Identifying Information and Availability

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2007 (revised 2012)

Guideline Developer(s)

American Medical Directors Association - Professional Association

Guideline Developer Comment

Organizational participants included:

- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- Direct Care Alliance
- Gerontological Advanced Practice Nurses Association
- LeadingAge
- National Association of Directors of Nursing Administration in Long Term Care
- The AMDA Foundation

Source(s) of Funding

American Medical Directors Association

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Clinical Practice Guideline Steering Committee

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Financial Disclosures/Conflicts of Interest

All contributors must submit an Accreditation Council for Continuing Medical Education (ACCME) approved disclosure form prior to being accepted as a volunteer member of the guideline workgroup. This disclosure form is reviewed by the chair of the American Medical Directors Association (AMDA) Clinical Practice Committee. If any conflicts are perceived, that person is not accepted to be part of the workgroup.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Health maintenance in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2007. 27 p.

Guideline Availability

Electronic copies: None available

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044.

Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com

Availability of Companion Documents

Table 8 in the original guideline document provides examples of sample performance measurement indicators for a health maintenance program in a long term care facility. The appendices to the original guideline document contain checklists, charts, and indices useful in guideline implementation.

Patient Resources

None available

NGC Status

This summary was completed by ECRI Institute on July 9, 2007. The information was verified by the guideline developer on August 23, 2007. This NGC summary was updated by ECRI Institute on August 9, 2013. The updated information was verified by the guideline developer on September 27, 2013.

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